I-Resolutions Inc.

An Independent Review Organization
3616 Far West Blvd Ste 117-501
Austin, TX 78731
Phone: (512) 782-4415
Fax: (512) 233-5110
Email: manager@i-resolutions.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Oct/20/2015

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE: LESI L3/4 on the right

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION: MD, Board Certified Physical Medicine and Rehabilitation

REVIEW OUTCOME: Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. It is the opinion of this reviewer that the request for a LESI L3/4 on the right is not indicated as medically necessary

PATIENT CLINICAL HISTORY [SUMMARY]: The patient is a female who reported an injury to her low back. The MRI of the lumbar spine dated xxxxxx revealed a broad based disc protrusion extend 2-3mm in the left lateral orientation with a partial extension into the left neural foramen. Mild to moderate left neural foraminal narrowing was also identified. The therapy note dated xxxxxxx indicates the patient having completed four physical therapy sessions to date. The clinical note dated 07/27/15 indicates the patient complaining of 10/10 low back pain. Radiating pain was identified into the right lower extremity. There is also indication the patient had numbness and tingling and weakness. Upon exam, reflexes were identified as normal. No sensation changes identified. There is indication patient demonstrated strength deficits with guarded range of motion. There is indication the patient had previously undergone visit to the emergency room where she was provided with a pain medication. The clinical note dated 08/03/15 indicates the patient continuing with 8-9/10 pain. The patient continued with subjective complaints of numbness and tingling in the lower extremities along with strength deficits. However, the clinical note indicates patient having undergone an exam which revealed normal reflexes and sensation.
There is indication the patient had decreased strength with guarded range of motion. The clinical note dated 08/14/15 indicates the patient having undergone x-rays of the lumbar spine which revealed essentially normal findings. X-rays of the lumbar spine dated 06/10/15 revealed no fracture or dislocations. No significant change were identified on the patient's clinical presentation. The clinical note dated 08/20/15 indicates the patient continuing with 7-9/10 pain. The patient described a sharp, stabbing, burning sensation, with pins and needles. The clinical note dated 10/08/15 indicates the patient continuing with 7-9/10 pain. Radiating pain was identified into the right lower extremity. And utilization reviews dated 08/07/15 and 09/21/15 resulted in denial as no neurological deficits were identified in the recent clinical exams.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND

CONCLUSIONS USED TO SUPPORT THE DECISION: The documentation indicates the patient has low back pain with radiating pain to the right lower extremity. The submitted MRI revealed mild to moderate left sided neural foraminal narrowing at L3-4. Additionally, no information was submitted regarding the patient's reflex, sensation or strength deficits identified in the L3 or L4 distributions. Given there is no information regarding any right sided symptomology confirmed by the MRI. Furthermore, no information was submitted regarding the patient's ongoing neurological deficits, specifically in the L3 or L4 distributions. Given these factors, the request is not indicated. As such, it is the opinion of this reviewer that the request for a LESI L3/4 on the right is not indicated as medically necessary and the prior denials are upheld.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

[ ] INTERQUAL CRITERIA

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

[ ] MILLIMAN CARE GUIDELINES

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

[ ] TEXAS TACADA GUIDELINES

[ ] TMF SCREENING CRITERIA MANUAL

[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)